

FEMALE HEALTH PRACTITIONERS DISCIPLINED FOR SEXUAL MISCONDUCT

JENNI MILLBANK*

Within a broader study of Australian tribunal determinations concerning sexual misconduct by the five major health professions (2010–17) it became apparent that a sizable minority of disciplinary cases were brought against female practitioners for engaging in sexual relationships with patients. This article examines cases involving female doctors, psychologists, and nurses to explore their distinctly gendered aspects. There were differences apparent between cases involving female and male practitioners, in terms of vulnerability of patients and degree of exploitation, which go some way to explaining an overall trend of less severe outcomes for female respondents in cases at the tribunal level. However, there were also issues that were entirely distinct in the female cases, being the occurrence of: incarcerated patients; patient suicide; and same-sex relationships. I suggest that the first two of these issues would generally be regarded as severely aggravating (but were not always assessed as such), while the complexity of the third in terms of the broader social context may not have been well understood. The distinctive features of female cases suggest that there may need to be a rethinking in order to target ethical guidance and training on sexual misconduct in a gender-specific way.

I INTRODUCTION

This project examined how sexual misconduct cases involving health practitioners are dealt with at tribunal level in Australia, in terms of how decision-makers characterised the seriousness of the conduct and how they articulated and weighed factors in determining protective orders. The tribunal setting is significant as the only public forum in which non-criminal complaints of sexual misconduct against health professionals are adjudicated, and as the site of consideration of

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matters determined to be most serious under the National Law.¹ In undertaking this analysis it became apparent that a sizable minority of disciplinary cases were brought against female practitioners working as psychologists, or in mental health settings, for engaging in sexual relationships with patients.

Recent years have seen increased public attention to the response of regulators to sexual misconduct and abuse by health professionals.² Around 3–6% of formal complaints about health practitioners in Australia concern sexual misconduct.³ A number of researchers exploring patient experience suggest sexual misconduct by health practitioners is underreported,⁴ and patients may be even less likely to report sexual misconduct than those who experience sexual abuse in other contexts.⁵ Furthermore, a lack of clear and consistent categorisation of sexual misconduct complaints and the associated lack of transparency concerning outcomes of complaints make it hard for researchers and the public to interrogate incidence, reporting rates or regulatory responses.⁶

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- 1 The majority of matters are finally disposed of through the National Boards (or in NSW, Council) system, in which neither proceedings nor outcomes are public: see discussion in Jenni Millbank, 'Health Practitioner Regulation: Has the National Law Produced National Outcomes in Serious Disciplinary Matters?' (2019) 47(4) *Federal Law Review* 631 ('Health Practitioner Regulation').
 - 2 See Ron Paterson, *Independent Review of the Use of Chaperones to Protect Patients in Australia* (Report, February 2017).
 - 3 Matthew J Spittal et al, 'Outcomes of Notifications to Health Practitioner Boards: A Retrospective Cohort Study' (2016) 14(1) *BMC Medicine* 198, 201 ('Outcomes of Notifications to Health Practitioner Boards'), finding 2.7%; Marie M Bismark et al, 'Sexual Misconduct by Health Professionals in Australia, 2011–2016: A Retrospective Analysis of Notifications to Health Regulators' (2020) 213(5) *Medical Journal of Australia* 218, 221 tbl 5, finding 3.4%. In NSW, the Health Care Complaints Commission ('HCCC') records 'sexual misconduct' as a subset within the 'conduct' complaint category. In 2018–19, the HCCC recorded that 6.2% of complaints within the conduct category were of sexual misconduct: Health Care Complaints Commission, *2018–19 Annual Report* (Report, 2019) 21. Note that a study of complaints against three complementary health professions between 2011 and 2016 found a higher proportion of complaints concerned 'sexual boundaries': physiotherapists (7.9%), chiropractors (10.3%) and osteopaths (17.1%): Anna T Ryan, Lay San Too and Marie M Bismark, 'Complaints about Chiropractors, Osteopaths, and Physiotherapists: A Retrospective Cohort Study of Health, Performance, and Conduct Concerns' (2018) 26(1) *Chiropractic and Manual Therapies* 12, 15.
 - 4 See, eg, Mary Halter, Hilary Brown and Julie Stone, 'Sexual Boundary Violations by Health Professionals: An Overview of the Published Empirical Literature' (Research Report, April 2007); Paterson (n 2) 27.
 - 5 Carolyn Quadrio, 'Sexual Abuse in Therapy: Gender Issues' (1996) 30(1) *Australian and New Zealand Journal of Psychiatry* 124; Merrillyn Walton, 'Sex and the Practitioner: The Predator' (2002) 34(1) *Australian Journal of Forensic Sciences* 7; Patricia Easteal, 'Suppressing the Voices of the Survivors: Sexual Exploitation by Health Practitioners' (1998) 33(3) *Australian Journal of Social Issues* 211, 211.
 - 6 The Australian Health Practitioner Regulation Agency ('AHPRA') does not record or release complaint data under the category of 'sexual misconduct' even though it is one of the four categories of serious conduct that trigger mandatory notification obligations. Rather, AHPRA complaints may appear under two categories: 'boundary violations' (which also includes non-sexual conduct such as confidentiality breaches), and 'offence against other law' (where the conduct has been the subject of criminal conviction prior to disciplinary proceedings; however, this category also includes a variety of other criminal offences). See discussion in Jenni Millbank, 'Serious Disciplinary Proceedings against Australian Health Practitioners for Sexual Misconduct' (2020) 44(1) *Melbourne University Law Review* (forthcoming) ('Serious Disciplinary Proceedings'). See also a discussion of the 'vague labelling' of United States ('US') medical disciplinary cases in James M DuBois et al, 'Sexual Violation of Patients by Physicians: A Mixed-Methods, Exploratory Analysis of 101 Cases' (2019) 31(5) *Sexual Abuse* 503.

International research on misconduct has noted that health practitioners engaging in improper sexual relationships are typically: male, in midlife, in the midst of marital disharmony, depressed and/or engaged in substance misuse, working in private practice, and involved with a younger female patient.⁷ There is no comparable ‘profile’ of female health practitioners engaged in sexual misconduct. Most recent research on women tends to address ‘sexual offences’ broadly and be largely focused upon large-scale analysis of criminal offending patterns.⁸ International studies that have addressed female offenders in professional settings have examined disciplinary reports concerning teachers⁹ and workers in incarceration settings.¹⁰ Taken together, these studies suggest that female offenders in professional contexts compared to male offenders in the same settings are typically: younger, more often inexperienced or early career (although still predominately mid-career), more likely to have abused only one victim, more likely to abuse a same-sex victim, abuse for a shorter period on average, less likely to repeat offend, and more likely to disclose backgrounds of childhood trauma themselves.¹¹

While this study addressed a small dataset of public cases, and no conclusions of statistical significance could be drawn, some findings reflect those of the international literature, including that female practitioners appeared unlikely to have a major age differential with the patient or to be involved with more than one patient. These would generally be considered as mitigating factors and go some way to explaining the trend of less severe outcomes faced by women which was apparent in this research. There were also three factors that were unique to female health practitioners in this dataset, being the presence of: incarcerated patients;

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- 7 See, eg, Matthew J Spittal et al, ‘Identification of Practitioners at High Risk of Complaints to Health Profession Regulators’ (2019) 19 *BMC Health Services Research* 380, 383; Glen O Gabbard, ‘Psychodynamics of Sexual Boundary Violations’ (1991) 21(11) *Psychiatric Annals* 651, 653; Glen O Gabbard, ‘Lessons to Be Learned from the Study of Sexual Boundary Violations’ (1996) 50(3) *American Journal of Psychotherapy* 311; Andrea Celenza and Glen O Gabbard, ‘Analysts Who Commit Sexual Boundary Violations: A Lost Cause?’ (2002) 51(2) *Journal of the American Psychoanalytic Association* 617.
 - 8 See, eg, Jeffrey Sandler and Naomi Freeman, ‘Female Sex Offender Recidivism: A Large-Scale Empirical Analysis’ (2009) 21(4) *Sexual Abuse* 455; Miriam Wijkman, Catrien Bijleveld and Jan Hendriks, ‘Women Don’t Do Such Things! Characteristics of Female Sex Offenders and Offender Types’ (2010) 22(2) *Sexual Abuse* 135; Jill Levenson, Gwenda Willis and David Prescott, ‘Adverse Childhood Experiences in the Lives of Female Sex Offenders’ (2015) 27(3) *Sexual Abuse* 258; Claudia van der Put et al, ‘Psychosocial and Developmental Characteristics of Female Adolescents Who Have Committed Sexual Offences’ (2014) 26(4) *Sexual Abuse* 330.
 - 9 See, eg, Peter Jaffe et al, ‘Emerging Trends in Teacher Sexual Misconduct in Ontario 2007–2012’ (2013) 23(1) *Education and Law Journal* 19 (examining 110 disciplinary cases and finding that 9.1% of offenders were women); Larissa S Christensen and Andrea J Darling, ‘Sexual Abuse by Educators: A Comparison Between Male and Female Teachers Who Sexually Abuse Students’ (2020) 26(1) *Journal of Sexual Aggression* 23.
 - 10 See, eg, Allen Beck, ‘Staff Sexual Misconduct: Implications of PREA for Women Working in Corrections’ (2015) 16(1) *Justice Research and Policy* 8. See also Christina Faulkner and Cheryl Regehr, ‘Sexual Boundary Violations Committed by Female Forensic Workers’ (2011) 39(2) *Journal of the American Academy of Psychiatry and the Law* 154.
 - 11 See Beck (n 10) 27; Andrea J Darling, Simon Hackett and Kimberly Jamie, ‘Female Sexual Offenders Who Abuse Children Whilst Working in Organisational Contexts: Offending, Conviction and Sentencing’ (2018) 24(2) *Journal of Sexual Aggression* 196.

patient suicide; and same-sex relationships. I suggest that the first two of these factors would likely be regarded as seriously aggravating, while the complexity of sexual misconduct involving a same-sex relationship may not have been well understood in terms of the broader social context, and deserves further attention in future.

Other researchers have contended that the important issue is not, as is so commonly posed, whether female offenders are ‘worse’ or ‘less worse’ than male offenders, but rather: what do we miss if we uncritically develop and apply knowledge derived only from male experience?¹² It is important, therefore, not just to compare, but also to consider what is *distinct* about female offenders. This article provides a qualitative textual analysis of the reasoning in sexual misconduct cases involving a relationship between a female health practitioner and patient or former patient to understand how and why such cases may be distinct from, or treated differently to, those involving male practitioners, in terms of the seriousness of the conduct, the risk to the public, and the determination of outcome.

This article first lays out the relevant professional proscriptions on sexual relationships and provides a brief overview of the dataset, before going on to examine the manner in which questions of vulnerability and exploitation arose, and were considered, in the female practitioner cases. The article then goes on to analyse the three factors that were distinct to the female practitioner cases and attempts to situate them within the study’s understanding of mitigating and aggravating elements, as well as within the context of the limited international research literature on female sexual offenders, particularly those who have committed sexual misconduct within a professional context.

II SEXUAL MISCONDUCT

All 15 regulated health professions in Australia have profession-specific Codes of Conduct which expressly proscribe entering into a sexual relationship with a patient.¹³ The medical profession is alone in providing detailed guidelines on

12 Franca Cortoni, ‘What Is So Special about Female Sexual Offenders? Introduction to the Special Issue on Female Sexual Offenders’ (2015) 27(3) *Sexual Abuse* 232, 232–3.

13 Optometry Board of Australia, *Code of Conduct for Optometrists* (undated) r 7.2; Nursing and Midwifery Board of Australia, *Code of Conduct for Nurses* (at 1 March 2018) r 4.1; Aboriginal and Torres Strait Islander Health Practice Board of Australia, *Code of Conduct for Registered Health Practitioners* (at 17 March 2014) r 8.2; Chinese Medicine Board of Australia, *Code of Conduct for Registered Health Practitioners* (at 17 March 2014) r 8.2; Chiropractic Board of Australia, *Code of Conduct for Chiropractors* (at 17 March 2014) r 9.2; Dental Board of Australia, *Code of Conduct for Registered Health Practitioners* (at 17 March 2014) r 8.2; Medical Radiation Practice Board of Australia, *Code of Conduct for Medical Radiation Practitioners* (at 17 March 2014) r 8.2; Occupational Therapy Board of Australia, *Code of Conduct for Registered Health Practitioners* (at 17 March 2014) r 8.2; Osteopathy Board of Australia, *Code of Conduct for Registered Health Practitioners* (at 17 March 2014) r 8.2; Paramedicine Board of Australia, *Code of Conduct for Registered Health Practitioners (Interim)* (at 15 June 2018) r 8.2; Pharmacy Board of Australia, *Code of Conduct for Pharmacists* (at 17 March 2014) r 8.2; Physiotherapy Board of Australia, *Code of Conduct for Registered Health Practitioners* (at 17 March 2014) r 8.2; Podiatry Board of Australia, *Code of Conduct for Registered Health Practitioners* (at 17 March 2014) r 8.2; Medical Board of Australia, *Good Medical Practice: A Code of Conduct for Doctors*

‘sexual boundaries’ which augment their Code of Conduct.¹⁴ These guidelines state that ‘[b]reaching sexual boundaries is always unethical and usually harmful for many reasons’, including power imbalance, trust, safety, quality (‘[a] doctor who sexualises patients is likely to lose the independence and objectivity needed to provide them with good quality healthcare’) and public confidence.¹⁵

In 2014 the Australian Health Practitioner Regulation Agency (‘AHPRA’), in conjunction with the National Boards, issued guidance on mandatory notification obligations applicable to all registered health professionals. This included definitional text on ‘sexual misconduct’ as follows:

Engaging in sexual activity with a current patient or client will constitute sexual misconduct in connection with the practice of the practitioner’s health profession, regardless of whether the patient or client consented to the activity or not. This is because of the power imbalance between practitioners and their patients or clients.

Sexual misconduct also includes making sexual remarks, touching patients or clients in a sexual way, or engaging in sexual behaviour in front of a patient or client. Engaging in sexual activity with a person who is closely related to a patient or client under the practitioner’s care may also constitute misconduct. In some cases, someone who is closely related to a patient or client may also be considered a patient or client; for example, the parent of a child patient or client.

Engaging in sexual activity with a person formerly under a practitioner’s care (i.e. after the termination of the practitioner–patient/client relationship) may also constitute sexual misconduct. Relevant factors will include the cultural context, the vulnerability of the patient or client due to issues such as age, capacity and/or health conditions; the extent of the professional relationship; for example, a one-off treatment in an emergency department compared to a long-term program of treatment; and the length of time since the practitioner–patient/client relationship ceased.¹⁶

The regulated health professions in Australia currently cover over 800,000 registrants, the majority of whom are female.

III CASE SET OVERVIEW

This work was undertaken as part of a broader study which analysed all publicly available Australian tribunal level decisions concerning complaints of serious misconduct and/or impairment brought against the five largest regulated health professions from 1 July 2010 to 30 June 2017. The overall dataset comprised 794 cases.¹⁷ The professions were, in order from most to least populous: nurses and midwives; doctors; psychologists; pharmacists; and dentists. There were 160 cases

in Australia (at 17 March 2014) r 8.2; Australian Psychological Society, *APS Code of Ethics (as adopted by the Psychology Board of Australia)* (at 2014) r C.4.3.

14 Medical Board of Australia, *Guidelines: Sexual Boundaries in the Doctor-Patient Relationship* (Guidelines, 12 December 2018).

15 *Ibid* 2.

16 Australian Health Practitioner Regulation Agency, *For Registered Health Practitioners: Guidelines for Mandatory Notifications* (Guidelines, 17 March 2014) r 3.4. These guidelines were revised and updated in 2020 (largely to distinguish obligations when the practitioner being notified is or is not a patient of the notifier): Australian Health Practitioner Regulation Agency, *Guidelines: Mandatory Notifications about Registered Health Practitioners* (Guidelines, March 2020).

17 See Millbank, ‘Health Practitioner Regulation’ (n 1).

involving a main claim of sexual misconduct, of which 150 involved at least one claim being proved, and a total of 10 cases in which the tribunal held that there was no case to answer concerning the claim of sexual misconduct (although there was still a finding of impropriety based upon a personal relationship in three of those 10 cases). Compared to their professional populations, doctors were over-represented and nurses under-represented. Men were over-represented in every professional group.¹⁸ Overall 80.4% of practitioners in sexual misconduct cases were male.¹⁹

The main category of 'sexual misconduct' was divided into two distinct secondary categories: 'relationship' and 'inappropriate contact'. There were no cases in which a female practitioner was accused of inappropriate contact (a category which included sexual harassment, unwanted touching and unjustified touching under a clinical pretext). When women engaged in sexual misconduct it was always within the context of a relationship.²⁰ Thus, it is misleading at the outset to compare female and male practitioners across the broad category of sexual misconduct because the subcategory of 'contact' is, in essence, a male category. Rather, the conduct of women has to be understood within the relationship category. Once the relationship category is taken as the focus, the proportion of women rises to a significant minority of matters at 27%.²¹

There were no relationship cases at all involving pharmacists of either sex, and of the four relationship cases which concerned dentists, none were female; hence this article concerns only doctors, nurses, and psychologists in relationships with patients. Among the 37 relationship cases involving doctors, only four were women (all of whom were General Practitioners); of 28 cases involving nurses, seven were women, and among 35 cases concerning psychologists, 17 were women. Female psychologists were the only group to appear at anything

18 Note that tribunal cases are not necessarily representative of the incidence and types of misconduct appearing in each profession, or even of the balance of formal complaints made to health regulators. Rather, they represent the matters deemed the most serious by regulators and referred to an independent tribunal for public resolution. However, the over-representation of male practitioners, and of doctors, is consistent through the disciplinary system: see Merylyn Walton et al, 'Profile of the Most Common Complaints for Five Health Professions in Australia' (2020) 44(1) *Australian Health Review* 15, 17–18.

19 Compared to a gender breakdown in the entire case set of the broader study of 795 cases, which was 65.8% male practitioners, 34.8% female practitioners: see Jenni Millbank, 'Serious Misconduct of Health Professionals in Disciplinary Tribunals under the National Law 2010–2017' (2019) 44(2) *Australian Health Review* 190, 193–4. While the broader study generated some statistically significant data, the set of 160 cases involving sexual misconduct was too small to produce statistical significance. Percentages and frequency tallies are used in this article to place the 28 cases concerning female practitioners into context, but are not relied upon for statistical significance. Note that a recent study of notifications concerning sexual misconduct in the period 2011–16 found that 88% of practitioners were male: Bismark et al (n 3).

20 Although one matter was coded as both 'contact' and 'relationship' because the male patient may have been underage at the time the relationship commenced: *Health Care Complaints Commission v McKeehan* [2013] NSWPSST 2 ('*McKeehan*').

21 See also the report of two US professionals who have, between them, evaluated or treated over 200 doctors, mental health professionals and clergy who have committed 'sexual boundary violations' and found that '15–20%' of those offenders were female: Celenza and Gabbard (n 7) 630.

approaching the gendered proportion of their professional population, although they were still under-represented compared to male psychologists.²²

Within the female sexual relationship cases – altogether 28 cases – psychologists were notably over-represented (n=17, 60%), whether comparing the five professional populations (of which psychologists comprised approximately 5.9% during the study period) or the professional spread within the larger misconduct case dataset of 795 cases (of which psychologists comprised 9.3%).²³ Mental health contexts appear to be a high risk setting for relationship-based misconduct.²⁴ Even within the female doctors and nurses in this study, mental health practice settings and presenting issues were the norm. Among the seven female nurses, five were practising in a mental health setting (including acute psychiatric wards, and inpatient drug and alcohol treatment facilities). Of the four doctors, three were treating the relevant patient primarily for mental health issues, for which they were also prescribing psychotropic medications.

A sexual relationship between practitioner and patient was judged to be of such seriousness as to constitute misconduct in almost every case in the dataset.²⁵ Consistent with other studies of both complaint data and tribunal decisions, sexual misconduct was the type of disciplinary offence most likely to lead to serious sanction.²⁶ In this case set, deregistration was ordered in 51% of proved relationship cases, with suspension the outcome in a further 36.5% of proved matters. Gender disaggregation of outcomes suggests that women received less severe sanctions, with women appearing more likely to be suspended and men appearing more likely to be deregistered. In proved sexual relationship matters 39.3% of female practitioners were deregistered (and 42.9% suspended), while 56% of male practitioners were deregistered (and 33.3% suspended). Furthermore, while the periods of suspension were almost identical (an average of 0.619 years for women, 0.621 years for men), the non-review periods ordered in conjunction with deregistration differed appreciably (an average of 1.91 years for women

22 In the study period, based on AHPRA registration data, women comprised on average 40.2% of registered doctors (and represented 10.8% of relationship cases involving doctors); 89.7% of registered nurses (and 25% of relationship cases involving nurses); and 78.8% of registered psychologists (and 48.6% of relationship cases involving psychologists).

23 See Millbank, 'Serious Disciplinary Proceedings' (n 6).

24 This is also the finding of a recent New Zealand study of a small number of tribunal disciplinary cases: see Lois J Surgenor, Kate Diesfeld and Marta Rychert, 'Consensual Sexual Relationships between Health Practitioners and Their Patients: An Analysis of Disciplinary Cases from New Zealand' (2019) 26(5) *Psychiatry, Psychology and Law* 766, 776.

25 There were two exceptions involving one female and one male practitioner. In *Medical Board of Australia v Petrovic* [2011] VCAT 795 ('*Petrovic*'), concerning a relationship some 14 years earlier, the male patient had worked at the clinic and had limited consultations with the female doctor, which ceased two months prior to the relationship commencing. The Victorian tribunal concluded that the relationship was more in the nature of a workplace romance. Likewise, in *Health Care Complaints Commission v Eftimoski* [2015] NSWCATOD 51, the NSW tribunal concluded that a longstanding and pre-existing social relationship between a male dentist and female patient meant that the therapeutic relationship was not dominant.

26 See Katie J Elkin et al, 'Doctors Disciplined for Professional Misconduct in Australia and New Zealand, 2000–2009' (2011) 194(9) *Medical Journal of Australia* 452; Spittal et al, 'Outcomes of Notifications to Health Practitioner Boards' (n 3); Lois J Surgenor et al, 'New Zealand's Health Practitioners Disciplinary Tribunal: An Analysis of Decisions 2004–2014' (2016) 24(1) *Journal of Law and Medicine* 239.

compared to 2.79 years for men).²⁷ At face value, this appears to support the commonly floated view that female sexual offenders ‘get off lightly’ compared to men.²⁸ However, there are distinctly gendered features of the relationship cases which may render such differences explicable. These differences must be understood within the evaluative matrix of disciplinary decision-making.

Each case is a discretionary decision under broad statutory grounds within a protective jurisdiction in which the health and safety of the public is a primary objective. Consistent with the guidance offered to the medical profession, tribunals frequently expressed the principle that sexual and intimate relationships between registered health practitioners and patients are inappropriate because they involve an underlying power imbalance and create a ‘dual’ relationship in which the practitioner is compromised in their duty to put the health needs of the patient first. Determinations of seriousness rested upon an assessment of the severity of the power imbalance. This was often expressed through the frame of vulnerability: both the vulnerability consequent upon the therapeutic relationship and the inherent vulnerability of the patient. This was accompanied by consideration of potential ‘exploitation’, often framed as a question of whether the conduct was ‘predatory’ or motivated by self-gratification as opposed to happenstance or a ‘genuine’ (although ill-considered) romantic attachment.²⁹

Determination of sanction rests upon broad considerations of the protection of public safety (with varying emphasis upon individual deterrence versus the general deterrence value or ‘signal’ to the profession about the seriousness of the conduct).³⁰ The question of future risk weighed heavily. So, for example, a one-off lapse of judgement from a practitioner who admitted the conduct, understood and accepted why it was a professional breach, could identify what circumstances had contributed to the breach and had taken steps to remediate was far less likely to lead to that practitioner being removed from practice (or if so, for a shorter time) than a practitioner who had engaged in the conduct with more than one patient, over a prolonged period, had kept treating the patient through the sexual

27 See also the finding of Christensen and Darling that among teachers disciplined for sexual misconduct with students in a small United Kingdom sample, while removal from practice was comparable between the sexes, men faced an average of four years as a non-review period, while the period for women averaged three years: Christensen and Darling (n 9) 28.

28 In the context of US criminal data, see, eg, Ryan T Shields and Joshua C Cochran, ‘The Gender Gap in Sex Offender Punishment’ (2020) 36(1) *Journal of Quantitative Criminology* 95. Concerning abuse within US prisons, see Brenda V Smith, ‘Uncomfortable Places, Close Spaces: Female Correctional Workers’ Sexual Interactions with Men and Boys in Custody’ (2012) 59(6) *UCLA Law Review* 1690, 1724. Although cf Beck, finding that of substantiated complaints in US prisons, male staff offenders were less likely to lose their jobs than female staff, equally likely to be arrested or referred for prosecution, and more likely to be reprimanded, disciplined or demoted: Beck (n 10) 30.

29 See also Medical Practitioners Tribunal Service and General Medical Council, *Sanctions Guidance For Members of Medical Practitioners Tribunals and for the General Medical Council’s Decision Makers* (Guidelines, 6 February 2018) 40–1 [142]–[148], which includes the categories ‘abuse of professional position’, ‘vulnerable patients’ and ‘predatory behaviour’.

30 Many of the cases involved an express finding that the female practitioner posed no risk to the public. Note that the tribunal case of *Do*, discussed below, led to the leading NSWCA case on sanction: *Health Care Complaints Commission v Do* [2014] NSWCA 307 (‘*Do*’), in which the Court found that the Tribunal had erred in focusing solely upon the specific risk posed by the practitioner and emphasised the goals of setting and maintaining professional standards and ensuring public confidence: at [35].

relationship, and/or denied, partially denied, or minimised the harmfulness of, the conduct.

Within this evaluative matrix, the cases involving female practitioners displayed a number of features likely to be associated with assessments of lesser seriousness. Notably, only one of 28 female practitioners was found to have engaged in a sexual relationship with more than one patient.³¹ In contrast, among the 75 male practitioners,³² 22% of them (n=17) faced allegations of sexual conduct concerning more than one patient, or had faced previous proceedings for sexual misconduct.³³ It also appeared that female practitioners were more likely to be engaged in an open and/or ‘primary’ romantic relationship with the patient rather than a secondary or clandestine sexual liaison, such that the relationship was less likely to be judged as ‘exploitative’ or ‘predatory’. Features such as the inherent vulnerability of the patient were referred to in the text of decisions inconsistently, and often in general terms. Nonetheless, of the 75 relationship cases involving a male practitioner, 29 decisions indicate that the patient had a past history of victimisation through sexual abuse or domestic violence, or a diagnosis of Post Traumatic Stress Disorder or Borderline Personality Disorder (themselves strongly associated with such abuse)³⁴ which was known to the practitioner.³⁵ There were no decisions in the female practitioner relationship cases that noted a patient history with such features.³⁶

Additionally, in four of the male practitioner relationship cases the decision noted that the practitioner himself committed an act or acts of violence upon the patient during the course of the relationship.³⁷ There was no comparable case in the female practitioner dataset, which conversely included one case in which the male patient was violent to the female practitioner.³⁸ This suggests that, in

31 *Psychology Board of Australia v D* [2011] VR 220/2010. Although note that in a further case there was an allegation of impropriety with a second male patient, which was not proved: *Health Care Complaints Commission v Nikolova-Trask* [2014] NSWCATOD 149 (‘Trask’).

32 There was one case, involving the internet grooming of a suicidal child patient, where the gender of the practitioner was suppressed in the decision: *Psychology Board of Australia v Registrant* [2013] QCAT 627 (‘The Registrant’).

33 See also Celenza and Gabbard’s finding that ‘most’ of the women in their cohort were only involved with a single patient: Celenza and Gabbard (n 7) 630.

34 Celenza and Gabbard note that in their experience, ‘many patients’ who are victims of sexual misconduct have histories of severe childhood trauma and also fall into the diagnostic spectrum of ‘Cluster B personality disorders or dissociative disorders’: Celenza and Gabbard (n 7) 625.

35 For examples of male practitioners whose patients had such characteristics to their knowledge, see *Psychology Board of Australia v Tunstall (Review and Regulation)* [2016] VCAT 1263 (‘Tunstall’); *Health Care Complaints Commission v Dawes* [2015] NSWCATOD 8 (‘Dawes’); *Health Care Complaints Commission v Talmadge* [2016] NSWCATOD 16; *Medical Board of Australia v Costley* [2013] WASAT 2; *Psychology Board of Australia v King* [2016] QCAT 140; *Medical Board of Australia v Visagie* [2013] TASHPT 2.

36 Although there was one ‘personal’ relationship case, discussed below under ‘Patient Suicide’, in which the female patient may have had dissociative identity disorder. This case was not counted among the 28 sexual relationship cases.

37 See *Health Care Complaints Commission v Ristevski* [2012] NSWMT 23 (‘Ristevski’); *Psychology Board of Australia v Cicconi (Review and Regulation)* [2013] VCAT 516; *Nursing and Midwifery Board of Australia v Hill-Murray (Review and Regulation)* [2013] VCAT 1603; *Medical Board of Australia v Chiappalone* [2014] QCAT 170.

38 *Health Care Complaints Commission v Scully* [2011] NSWNMT 28 (‘Scully’), discussed below.

analysing health practitioner relationship-based sexual misconduct, broader societal gendered power dynamics should not be lost sight of.

In the following Parts, I examine how considerations of vulnerability and exploitation appeared and played out in the cases concerning female practitioners. While the above factors go some way towards explaining an overall trend of findings of lesser seriousness concerning female practitioners, there were some strong cross-currents as well, including an apparent inability of many female practitioners to perceive their male patients as vulnerable, and a tendency to confuse the provision of care and nurturing with romance in circumstances of crisis.

IV VULNERABILITY

Inherent vulnerability may arise because of a person's social background (such as poverty, youth or old age, or migration status) or specific life events (acute or chronic illness, substance addiction, background of trauma, childhood sexual abuse or domestic violence).³⁹ Disciplinary decisions, unsurprisingly, placed a great deal of stress upon the health status of the patient, and the extent to which that information was known to the practitioner, in assessing vulnerability.

There is also the relational vulnerability that arises from the therapeutic relationship; thus, the more intimate, trust-based and extensive the treating relationship, the more acute the vulnerability of the patient was understood to be. In cases involving mental health professionals, even brief treating relationships (such as two or three sessions with a psychologist) were taken to establish acute vulnerability, by virtue of the context of the treatment and nature of the treating relationship.

As noted above, female respondents appeared markedly less likely than male practitioners to be involved with patients with an acknowledged history of sexual abuse or domestic violence, or a diagnosis of Borderline Personality Disorder. However, this did not mean that their patients were not vulnerable, or that they were not characterised as vulnerable by decision-makers. To the contrary, several of the male patients were clearly inherently vulnerable by reason of health conditions which included chronic alcoholism, substance abuse, depression, schizophrenia and – in one of the few cases not arising from a mental health setting – mesothelioma (along with HIV and Hepatitis C).⁴⁰ What was striking was how commonly female practitioners initially (and sometimes, continually) contested the idea that their male patient was 'vulnerable'. In one case the General

39 See Samia Hurst, 'Vulnerability in Research and Health Care: Describing the Elephant in the Room?' (2008) 22(4) *Bioethics* 191. See generally Johnathan Herring, *Vulnerable Adults and the Law* (Oxford University Press, 2016).

40 Four cases involved substantial age differentials of 15+ years between the female practitioner and patient: *Health Care Complaints Commission v Brown* [2013] NSWNMT 8 ('Brown'); *Psychology Board of Australia v van Megchelen* [2013] VCAT 328 ('van Megchelen'); *McKeehan* [2013] NSWPSST 2; *Psychology Board of Australia v Dall* [2011] QCAT 608 ('Dall').

Practitioner ('GP'), who had treated a man over a period of years including for hypertension, high cholesterol and a testicular lump, stated at the hearing:

[He] was quite a healthy man who did not require any extensive care. The care I provided to him was very superficial and very basic and ... I did not feel that I'm in a position of power, where I can abuse my power, where he's vulnerable at all.⁴¹

The Tribunal rejected this characterisation, and moreover held that it reflected poorly on the practitioner.

In at least five cases, the male patient himself participated in the disciplinary process in support of the female practitioner. In the only two of those matters where the improper relationship was conceded by the practitioner, the patient *himself* vigorously objected to being characterised as vulnerable. In *Health Care Complaints Commission v Scully* ('Scully'), the man had been an inpatient at an acute psychiatric ward for two months, with a diagnosis of chronic schizophrenia and polysubstance abuse. He was then discharged under a community treatment order, under the supervision of the hospital, which included the depot provision of antipsychotic medication. During investigation, the patient (who at that time was still in the relationship) wrote to the regulator saying that the relationship 'has never been detrimental to my mental health' and that he felt 'extremely violated' by the investigation.⁴² The Tribunal was strongly critical of the nurse, finding that she had harmed the patient through engaging in the relationship, consuming drugs with the patient, and encouraging the patient in challenging his diagnosis and seeking a reduction in his medication, and that she lacked insight into all of the above. In common with a number of the cases involving prisoners, the patient in that matter had a history of violent conduct. Towards the end of the relationship the nurse obtained an Apprehended Violence Order against the patient, and there were court proceedings when that order was breached. The Tribunal noted that even by the time of the disciplinary hearing some years later,

[s]he saw herself as the victim. She said she was good for Patient A's mental health, but he [was] not for hers. She considered herself abused by him and that she had to leave the relationship because of his preference for drugs over her.⁴³

The above quote was expressly part of the Tribunal's reasoning to the conclusion that the nurse lacked remorse or contrition, not in any way as mitigating the seriousness of her conduct.⁴⁴

Ms Scully did accept in her oral testimony that a power imbalance arose by reason of her access to the patient's history, and that she therefore had the 'upper hand', but she did not resile from her position that the patient himself was abusive. Interestingly, in an application for reinstatement two years later she framed this as the patient posing a future risk to other nurses, as follows:

[There is the possibility that the patient] would become unwell because he would be off the medication and there is the fact that he is very sexually inappropriate towards the nurse. Now by me having an intimate relationship with him as a nurse,

41 *Trask* [2014] NSWCATOD 149, [89].

42 *Scully* [2011] NSWNMT 28, [64].

43 *Ibid* [129].

44 See also Christensen and Darling's finding that three female teachers who claimed that they were, in effect, the victim were met with 'denunciation' by the disciplinary panel: Christensen and Darling (n 9)

he then gets the idea any nurses are fair game. So if he is unwell and in hospital, his sexual inappropriateness would [be] tenfold and then that would put nurses, that are meant to look after him, at risk. So indirectly I have actually done that.⁴⁵

This perspective highlights the complexity of power issues in a setting in which gendered power differentials, particularly those concerning violence, interact with the lower hierarchical position and physical accessibility of the (overwhelmingly female) profession of nurses.

In *Health Care Complaints Commission v Waddell* ('Waddell'), the man had been an inpatient at a private hospital.⁴⁶ The nurse argued that the patient, a successful professional man of similar age to herself, was not in any way vulnerable, and that they had 'an open, loving, and socially known relationship'.⁴⁷ The patient wrote to the regulator disputing its characterisation of him (presumably in a letter of complaint to the nurse) as a 'vulnerable patient who was dependent on nursing and medical care both physically and mentally'. He asserted that he was 'at all times completely in charge of my mental faculties and was no more dependent on Ms Waddell than I was on other members of the nursing staff'.⁴⁸ The practitioner also furnished affidavits from the patient's colleagues, friends and his mother attesting to his lack of vulnerability and robust intellectual capacity at the time of the relationship.

As occurred in *Scully*, the Tribunal in *Waddell* gave little weight to the assertion of non-vulnerability by the male patient, focusing instead on his medical condition and the care setting. In finding that the patient was in fact a 'very vulnerable individual', the Tribunal noted that the medical records 'detail a long history of poor self-care, as well as medical and nutritional, social, and financial problems', finding that the nurse 'was apprised of deeply personal information about Patient A's problems', and that 'it was very clear from the records that the problems were entrenched and chronic, and there was a pattern of relapse'.⁴⁹ The Tribunal noted,

[w]ith all due respect to Patient A, the Tribunal is of the view that the subjective self-view from a person who suffers chronic alcoholism and depression, and attendant physical maladies, may not be the best way to determine that person's level of vulnerability with respect to another person who essentially represents care and nurture to them.⁵⁰

Practitioners not infrequently led evidence that they were themselves 'vulnerable' as a result of their life circumstances or health conditions, through reports from treating practitioners or their own testimony. In the relationship cases as a whole, personal situations involving depression and marital disharmony were very common, and claims of female practitioner 'vulnerability' arising from divorce or marital strife were generally given little, if any, weight.⁵¹ However,

45 *Scully v Health Care Complaints Commission* [2013] NSWNMT 7, [66].

46 *Health Care Complaints Commission v Waddell* [2012] NSWNMT 17, [14] ('Waddell'). See *Health Care Complaints Commission v Waddell [No 2]* [2013] NSWNMT 2 for orders.

47 *Waddell* [2012] NSWNMT 17, [183].

48 *Ibid* [188].

49 *Ibid* at [196], [195] and [198] respectively.

50 *Ibid* [199].

51 See, eg, *Health Care Complaints Commission v Ledner* [2017] NSWCATOD 90 ('Ledner'); *Trask* [2014] NSWCATOD 149.

practitioners who had suffered a recent bereavement in an intimate relationship were considered more personally fragile,⁵² as was a nurse with a history of sexual abuse who engaged in a relationship with a prisoner who was a manipulative serial sexual offender.⁵³ In those cases, although misconduct was still found, the decisions suggest that the conduct was not judged at the highest end of seriousness.

I suggest that using the terminology of ‘vulnerability’ to characterise a practitioner’s personal frailties or difficult circumstances rather muddies the waters in such cases,⁵⁴ as it risks losing sight of the vulnerability of the patient and of the relational imbalance that inheres in the professional relationship, regardless of the practitioner’s circumstances.⁵⁵ In particular, given the difficulty that female offenders appeared to have in identifying the vulnerabilities in their male patients, it may be more useful to avoid such terminology in relation to the practitioner and instead characterise such contributory factors as ‘susceptibilities’ or ‘stressors’. Regardless of whether such matters are taken into account as mitigating factors, if they were associated with the occurrence of the misconduct, then they remain relevant to the determination of risk of recurrence.

While female practitioners tended to focus more on the specific interpersonal dimensions of their relationship with the male patient in disclaiming or contesting vulnerability, the tribunal decisions placed a lot of weight on the structural vulnerability arising from the therapeutic relationship. The reasoning in many decisions explicated the interlocking dimensions of the therapeutic relationship which rendered the patient vulnerable – even if he did not believe himself to be so at the time. In a case concerning a young and inexperienced psychologist, the Tribunal illustrated this by quoting evidence from the patient:

Initially I did not feel there was a power imbalance between Brooke and I. I fel[l] quite hard for her. I now realise that she had complete control over me, for example, if we argued she would bring up things I had confided to her during counselling.⁵⁶

The conflict of interest and abuse of power inevitably resulting from such a merging of professional and personal position was well illustrated in *Health Care Complaints Commission v Amigo* (‘*Amigo*’). In that case the GP, very concerned for her partner/patient’s poor mental health, referred him on a mental health plan to a psychologist, and also to a psychiatrist, without disclosing the relationship to either of them. She then proceeded to receive a series of what would otherwise be highly confidential reports about her partner from those professionals over a lengthy period, including reports of his distress when his new relationship (with

52 *Brown* [2013] NSWNMT 8, [93]; *Psychology Board of Australia v Garcia (Review and Regulation)* [2015] VCAT 128, [42].

53 *Health Care Complaints Commission v Karja* [2012] NSWNMT 11 (‘*Karja*’).

54 See, eg, a finding that the practitioner was still ‘vulnerable’ regarding boundaries because she was still treating two patients who were family friends: *Health Care Complaints Commission v Amigo* [2012] NSWMT 13, [40] (‘*Amigo*’). Such characterisation leads to consideration of the practitioner as ‘at risk’ rather than as *the risk* to be assessed.

55 Cf Surgenor, Diesfeld and Rychert who appear to suggest that taking into account a practitioner’s ‘vulnerability issues’ are an appropriate expression of therapeutic jurisprudence: Surgenor, Diesfeld and Rychert (n 24) 771.

56 *Ledner* [2017] NSWCATOD 90, [66].

her) broke down.⁵⁷ In cases such as *Amigo*, the well-motivated intentions of the practitioner (and subjective sense of her own role as ‘helping’) were thus incidental compared to the serious structural imbalance undergirding the therapeutic relationship. However, the question of the practitioner’s motivation and ‘genuineness’ was still a prominent consideration in the assessment of whether the conduct was ‘predatory’, as discussed below.

V EXPLOITATION VS ‘GENUINE ROMANCE’

The fact that all but one of the female practitioners were judged as having engaged in a ‘once off’ improper relationship was highly significant in relation to assessments of seriousness and in determination of outcome. A single patient meant that practitioners were far more likely to be adjudged ‘genuine’ rather than as ‘predatory’ in their conduct. This characterisation was strongly reinforced by the fact that in 19 of the 28 female practitioner cases the relationship was a medium or long-term one and was a primary relationship rather than an ‘affair’ or clandestine sexual liaison. Even in cases in which the female practitioner was married at the time the relationship began, it was more common than not for her to leave her spouse for the patient.⁵⁸ In at least three cases the practitioner and patient were still together at the time of the hearing,⁵⁹ and the partner attended in support of the practitioner in some cases. In two cases the practitioner had given birth to the patient’s child.⁶⁰ In the context of enduring relationships, while the conduct was still assessed as a serious breach of professional duties, it was also viewed as misguided ‘romance’⁶¹ as opposed to mere self-gratification or wilful abuse,⁶² and so the practitioner was not held to pose any risk to the public through systemic ethical failure.

The predominance of mental health settings suggests that risk of sexual boundary violations must be understood as high in such contexts. Observations drawn from authors such as Gabbard may therefore be particularly apt to assist in understanding the dynamics at play in such cases. Celenza and Gabbard have based their observations on around 200 United States (‘US’) mental health practitioners and clergy who acknowledged having committed sexual misconduct and whom

57 *Amigo* [2012] NSWMT 13.

58 See, eg, *Ledner* [2017] NSWCATOD 90; *Amigo* [2012] NSWMT 13. The exception is *Petrovic*, but that relationship was characterised as mutual and collegial in nature rather than as exploitative: *Petrovic* [2011] VCAT 795.

59 See, eg, *Trask* [2014] NSWCATOD 149, [6] (three-month suspension); *Psychology Board of Australia v Bakjac* [2016] SAHPT 3, [5] (15-month suspension). See also *Health Care Complaints Commission v Bergmeier* [2014] NSWCATOD 75, [104] (‘*Bergmeier*’); and possibly also *Dall* [2011] QCAT 608.

60 See *Trask* [2014] NSWCATOD 149, [6]; *McKeehan* [2013] NSWPS 2, [6].

61 For cases in which male practitioners were characterised as ‘genuine’, see, eg, *Medical Board of Australia v Jones* [2012] QCAT 362 (two-month suspension); *Medical Board of Australia v Leggett* [2015] QCAT 240 (‘caring and intimate’ relationship with former psychiatric patient of 10 years, no removal from practice).

62 For cases in which male practitioners were characterised as predatory or self-gratifying, see, eg, *Risteovski* [2012] NSWMT 23; *Medical Board of Australia v Love* [2013] QCAT 608; *Tunstall* [2016] VCAT 1263; *Dawes* [2015] NSWCATOD 8.

they had separately evaluated or treated over many years. They claim that the majority of offenders, around three quarters overall (and almost all of the women in their cohort) committed misconduct with only one patient.⁶³ They posit that many ‘one-time transgressors’ – who are otherwise ethically sound and competent – belong to a category they label ‘lovesick’, whom they describe as follows:

For the lovesick group, the sexual relationship is experienced by both participants, at least for a time, as a true love affair. They usually share a fantasy that each is rescuing the other and that they are soulmates who understand each other’s needs like no one else ... Role reversals occur in which the analyst or therapist discloses personal problems to the patient ... Finally, the analyst or therapist is typically in the midst of a life crisis such as divorce, a lifeless marriage, illness or death in the family ...⁶⁴

Gabbard contrasts this group to those he categorises as ‘sexually exploitative’ therapists with psychopathic traits, whom he identifies as ‘often sexually involved with multiple patients’.⁶⁵

The ‘lovesick’ description chimes true of many of the female practitioners in the cases analysed here. For example in *Scully*, although a colleague ‘kept telling her’ that she was in breach of the Code of Conduct in her openly conducted relationship with a mental health patient subject to a community treatment order, the practitioner informed the Tribunal:

I would just say, ‘It’s too late ... I’m already in love with this man, I can’t help who I fall in love with. I can’t just stop being in a relationship with him’.⁶⁶

Gabbard suggests that in therapeutic relationships, ‘many sexual boundary violations grow out of misguided efforts to love the patient back to health’;⁶⁷ that is, the improper relationship is itself understood by the practitioner at the time as an *extension* of care from the therapeutic relationship, as ‘helping’. However, Celenza and Gabbard also posit from their clinical experience that the lovesick group are only remediable if they ‘move on’ and are genuinely remorseful, whereas if they stick to the ‘true love’ narrative then they are likely to be unreflective and unethical.⁶⁸ If this is an accurate assessment, it suggests that for those practitioners in continuing relationships with patients who have become spouses or de facto partners in the meantime there is a difficult line to tread between being ‘genuine’ and being unrepentant at the time of hearing.

63 Celenza and Gabbard (n 7) 618, 630.

64 Ibid 623.

65 Gabbard, ‘Psychodynamics of Sexual Boundary Violations’ (n 7) 652; see also Glen O Gabbard, Morris L Peltz and COPE Study Group on Boundary Violations, ‘Speaking the Unspeakable: Institutional Reactions to Boundary Violations by Training Analysts’ (2001) 49(2) *Journal of the American Psychoanalytic Association* 659.

66 *Scully* [2011] NSWNMT 28, [61].

67 Gabbard, ‘Lessons to be Learned from the Study of Sexual Boundary Violations’ (n 7) 314.

68 Celenza and Gabbard (n 7) 629 state:

An essential characteristic that argues for potential rehabilitation is the presence of genuine remorse. Does the transgressor take full responsibility for the misconduct and demonstrate that he or she profoundly regrets what happened? Can he or she empathize with the damage inflicted on the patient and on the profession? ... Remorse must be rigorously differentiated from narcissistic mortification. The latter refers only to regret for the ways in which the misconduct has damaged one’s sense of self-regard, self-worth, and reputation

There were a limited number of cases in which the tribunal appeared to accept the ‘genuine’ nature of the relationship as mitigating. In the case of *Psychology Board of Australia v Dall*, a psychologist was involved in a romanticised relationship with a prisoner who was 20 years her junior. In that case the Tribunal listed under ‘mitigating factors’:

Although his incarceration meant the patient was vulnerable, there is no evidence of predatory conduct by Ms Dall ... [who] has a genuine concern for the welfare of this patient, albeit her professional judgment about how to best support him was clouded by her emotional involvement with him.⁶⁹

This approach was fairly exceptional. However, it does highlight the striking clash of mitigating and aggravating cross-currents which arose particularly in matters involving incarcerated patients, in which several female practitioners exhibited ‘rescuing’ behaviours and rationales.

Celenza and Gabbard suggest that at the far end of the ‘lovesick’ group there is a smaller group of offending practitioners whom they describe as involved in ‘masochistic surrender’, in that they engage in a ‘self-destructive rescue fantasy’⁷⁰ with a very unwell patient (and often themselves unravel in the process).⁷¹ While the incarcerated patients and patient suicides, both discussed below, display many indicia of acute patient vulnerability and other aggravating factors that tend towards an assessment at the most serious end, the practitioners also could be broadly grouped within Gabbard’s characterisation of ‘masochistic surrender’ in that they ‘overidentified’ with the patient’s suffering and engaged in ‘heroic and misguided treatment efforts’.⁷²

VI INCARCERATED PATIENTS

In a dataset of 28 cases over seven years, it is striking that there were nine cases of a female practitioner in an intimate relationship with an incarcerated or detained male patient⁷³ (with several more cases apparent outside of the study period).⁷⁴ Six

69 *Dall* [2011] QCAT 608, [62]. This was a somewhat surprising characterisation given that the practitioner had engaged in a range of deception in association with the relationship, and that both she and the patient had given false evidence on her behalf.

70 In the context of female offenders in professional contexts (such as teaching) engaged in sexual abuse of juveniles, Christensen and Darling utilise a similar category of ‘saviour syndrome’: Christensen and Darling (n 9) 25–6.

71 Celenza and Gabbard (n 7) 624–5.

72 Ibid 630.

73 These were: *McKeehan* [2013] NSWSPST 2; *Health Care Complaints Commission v Senior* [2015] NSWCATOD 50 (‘Senior’); *Dall* [2011] QCAT 608; *Health Care Complaints Commission v Leighton* [2016] NSWCATOD 33 (‘Leighton’); *Psychology Board of Australia v Duangpatra* [2012] QCAT 514 (‘Duangpatra’); *Nursing and Midwifery Board of Australia v Maguire* [2013] VR 119/2013 (offshore immigration detention); *Karja* [2012] NSWNMT 11; *Brown* [2013] NSWNMT 8; *Bergmeier* [2014] NSWCATOD 75.

74 Outside of the study period, see *Health Care Complaints Commission v Sunjic* [2008] NSWNMT 12; *Cunningham v Health Care Complaints Commission* [2007] NSWNMT 1; *Health Care Complaints Commission v Mead* [2007] NSWSPST 3. Within the period but excluded by coding, see *Nursing and Midwifery Board of Australia v Tainton* [2014] QCAT 161 (romantic communications but no physical relationship). Also note that in a recent study addressing 14 years of New Zealand tribunal cases, three

matters involved psychologists and three involved nurses. There were no comparable cases in the dataset involving a male practitioner with a female prisoner.⁷⁵ It is clear that these cases were seen as very serious forms of misconduct: only two matters resulted in suspension⁷⁶ while seven resulted in deregistration, with an average non-review period of 2.2 years.

There is no available data on the sexual misconduct of female staff in Australian prisons. Internationally, there is an emerging body of work arising from the collection of large-scale centralised data on sexual misconduct in US federal prisons. Allen Beck's analysis of such data, drawing upon both inmate surveys and analysis of substantiated complaints against staff covering the period 2011 to 2012, shows women offending at a disproportionate rate to their professional numbers, even more so with juvenile inmates. Although female sexual misconduct overwhelmingly involved 'willing' prisoners rather than those who were coerced (in direct contrast to male offenders),⁷⁷ incidents with juvenile inmates were strongly associated with drugs, alcohol and gifts, which were characterised as forms of 'nonphysical coercion' in reports.⁷⁸ It is notable that in the substantiated complaints of sexual misconduct concerning prison staff, 15% of the female staff were medical, health care or counselling staff (compared to only 5% of the male staff).⁷⁹ This suggests that female health practitioners engaging in sexual misconduct in prison settings may be a pervasive problem.

In a separate study of 549 files of Texas prison employees disciplined for misconduct from 1995–98, Marquart, Barnhill and Balshaw-Biddle found that most staff disciplined for wrongdoing were female, and that 'dual relationships' and 'sexual contact' were the main issues.⁸⁰ This research is important because it provides a qualitative analysis to such cases. Through lengthy quotation of intercepted correspondence between prisoners and staff, the authors examined the intense fantasies of romantic rescue in many matters, leading them to conclude that these cases paralleled the dynamics of psychotherapist–patient relationships described by Gabbard and others, in terms of the background stressors in the lives of staff (bereavement or other loss) and intense emotional (over)identification with a 'soulmate' and ensuing 'lovesickness'.⁸¹

Gabbard has elsewhere suggested, based on his observations, a distinct 'pattern' concerning female practitioners and impulsive, often substance abusing, 'wayward' young male patients, in which the female therapist is drawn to him 'with an unconscious fantasy that her love and attention will somehow influence

cases involved a female practitioner and male patient in correctional settings (two psychologists and one nurse): Surgenor, Diesfield and Rychert (n 24) 775.

75 Cf *Health Ombudsman v Kimpton* [2018] QCAT 405, which was outside of the study period.

76 *Duangpatra* [2012] QCAT 514; *Karja* [2012] NSWMT 11.

77 83.5% of female staff fell into the category of sexual relationship that 'appeared to be willing', compared to 36.8 % of male staff: Beck (n 10) 14.

78 *Ibid* 18.

79 *Ibid* 29–30.

80 James Marquart, Maldine Barnhill and Kathy Balshaw-Biddle, 'Fatal Attraction: An Analysis of Employee Boundary Violations in a Southern Prison System, 1995–1998' (2001) 18 *Justice Quarterly* 877, 895–7, 901–2.

81 *Ibid* 906.

this essentially decent young man' to 'straighten up'.⁸² Gabbard notes that such dynamics reflect a cultural trope in which female romantic devotion restores disruptive or unruly masculinity to order (viz: the love of a good woman).⁸³

Many of the incarceration cases in this dataset could be viewed with such a lens; in particular as most of the practitioners understood the relationships as romances that would continue upon his release from prison, and some did so.⁸⁴ However, these cases also involved very serious indicia of vulnerability on the part of the patients, in addition to the vulnerability consequent upon their (often lengthy) incarceration. While most decisions contain little detail concerning the patient (as the patient identity is generally suppressed), it was noted in most matters that the patient had a serious mental health issue or diagnosis, including schizophrenia, schizoaffective disorder, suicidality and substance dependence. At least two of the patients were being treated with antipsychotic medication at the time of the misconduct. All of the patients were thus highly vulnerable in terms of both individual and contextual factors.

At the same time, it was apparent that at least four of the patients were violent offenders with histories of sexual violence and 'predatory sexual behaviour'.⁸⁵ The issue of vulnerability in this context is complex. In the case of *Health Care Complaints Commission v Karja*, the peer expert opined that 'balance of power may have favoured [Patient A]' based upon evidence of the patient's sociopathic qualities and the nurse's own history as a victim of abuse.⁸⁶ While the Tribunal noted the patient's vulnerability by reason of his health condition and the fact that in an incarceration setting, a patient's vulnerability is exacerbated because he has no choice of health care provider, it appears that the expert view held some sway – as it was one of only two cases which resulted in suspension instead of deregistration. By contrast, in the case of *Health Care Complaints Commission v Senior*, the fact that the forensic psychologist was treating the patient in a sex offender program when she engaged in the improper relationship (including sexualised conduct on her part that was demeaning to women) was squarely characterised as 'reprehensible' conduct on her part, with a damaging impact upon both the patient's treatment and upon public safety.⁸⁷

Whatever view was taken of the practitioner's genuineness and the degree of relative vulnerability of the patient, the incarceration cases featured a number of other elements associated with assessments of severity. In particular, almost every case involved a serious abuse of professional position during the dual relationship. This included, for example, the practitioner using her professional role to advocate on the prisoner's behalf,⁸⁸ authoring reports or conducting health assessments that affected his circumstances without disclosing the relationship,⁸⁹ and even

82 Gabbard, 'Psychodynamics of Sexual Boundary Violations' (n 7) 654.

83 Ibid.

84 See, eg, *McKeehan* [2013] NSWST 2; *Bergmeier* [2014] NSWCATOD 75; *Leighton* [2016] NSWCATOD 33.

85 See, eg, *Brown* [2013] NSWNMT 8, [24].

86 [2012] NSWNMT 11, [18], [25], [31].

87 [2015] NSWCATOD 50, [133].

88 *Dall* [2011] QCAT 608, [8].

89 *Ibid* [50]; *Senior* [2015] NSWCATOD 50, [4]; *Bergmeier* [2014] NSWCATOD 75, [38].

falsifying records.⁹⁰ Practitioners in these cases went to considerable lengths to deceive their employers in order to maintain the relationship, often over long periods, including actually changing their names, registering phones in false names, falsifying records to minimise the treating relationship or recent contact, using a false name to contact the prisoner and to sponsor him on weekend leave or conditional release, and smuggling goods in to him. In a number of matters this pattern of deception carried over into complete denials of the improper relationship at initial investigation, and ongoing partial denials subsequently. In the sexual misconduct cases more broadly, dishonesty in dealing with investigations and regulators was widely regarded as an aggravating factor, and was more likely to result in deregistration rather than suspension or other less restrictive sanction.⁹¹

In sum, the incarceration setting appears a high-risk context for sexual misconduct by female health practitioners. In this setting there were severe power imbalances and acute patient vulnerability, both in an individual and a relational sense, as most patients had serious mental health conditions, restricted access to health care and limited access to other relationships or support services. Furthermore, most matters were accompanied by multiple abuses of professional position and responsibility, particularly through deception of employers and investigators. In this sense, the incarceration sexual misconduct cases could be seen as among the most serious of any in the health disciplinary system. Yet the presentation of vulnerability and issue of exploitation were also complex, particularly in cases in which the patient was a sexual offender himself. There was also the somewhat perplexing ‘rescue’ posture of some practitioners, who appeared to understand the improper relationship as an extension of their caregiving efforts. This is explored further below in relation to patient suicidality.

VII PATIENT SUICIDE

Only one case within the main category of sexual misconduct involved a patient suicide: *Amigo*.⁹² However, there were two further cases in the overall misconduct dataset in which a female GP’s patient also died by suicide. While those two additional cases were not coded within the main category of ‘sexual misconduct’, both involved a ‘dual’ intimate relationship. In the case of *Health Care Complaints Commission v Do*, the doctor and male patient were in a de facto relationship but the case was not coded under the main head of ‘sexual misconduct’ because the sexual relationship had predated the treating relationship and the main issue in the complaint concerned her prescribing conduct.⁹³ In the case of *Medical Board of Australia v Wild* (‘*Wild*’), the doctor and female patient were involved in a personal relationship that included holidaying together, overnight stays, gifts of money and daily telephone contact over a five year period.⁹⁴ All three cases bear

90 *Bergmeier* [2014] NSWCATOD 75, [17].

91 Millbank, ‘Serious Disciplinary Proceedings’ (n 6).

92 *Amigo* [2012] NSWMT 13.

93 *Health Care Complaints Commission v Do* [2012] NSWMT 9 (‘*Do*’).

94 [2012] WASAT 37 (‘*Wild*’).

strong thematic links which merit consideration in terms of the enmeshment of the patient suicidality with the practitioner's perception of care provision through the improper relationship and her active avoidance, or undermining of, outside care.⁹⁵

Each of these matters involved a patient who committed suicide by drug overdose undertaken on a second or subsequent attempt at suicide, who was in an intimate relationship with a female GP managing them for complex mental health conditions and also prescribing for them.⁹⁶ It is striking that each of these doctors persistently denied that there was a dual relationship. Throughout the investigation stage, Dr Amigo's position was that the therapeutic relationship had ended before the sexual relationship (despite ongoing mental health referrals and some prescribing), although by the time of the hearing she conceded that there was overlap. Throughout the disciplinary hearing, Dr Do denied that there was *ever* a therapeutic relationship (despite Medicare billing, multiple treatment referrals, and prolonged extensive prescribing described in the decision as 'chaotic' and 'grossly inappropriate polypharmacy').⁹⁷ Despite accepting at the tribunal hearing that the relationship was 'inappropriate' and without boundaries, in later coronial proceedings Dr Wild continued to characterise her daily phone calls, secret notes, and frequent home visits with her patient as 'an informal extension' of her counselling role rather than an improper personal relationship.⁹⁸ It was also striking that, in the face of very serious breaches, and catastrophic outcomes, all three practitioners clung to the view that they had been 'helping' the patient in question.

In these three cases, the improper relationship arguably impeded the patient from obtaining the kind of serious or sustained mental health care that they required. Although Dr Amigo did refer her patient to both a psychologist and a psychiatrist, she concealed the relationship from them, did not notify the psychologist of the patient's suicidality nor a later deterioration in his mental state, and did not alert either professional that the patient was in possession of phenobarbitone.⁹⁹ Dr Do rationalised her involvement and overprescribing of multiple drugs over a lengthy period on the basis of the patient's distrust of health professionals.¹⁰⁰ It appears that Dr Do believed that she was the only person who could adequately care for the patient, at the same time that she denied being in a treating relationship or acting as a primary care provider. In the process of involving multiple other professionals, Dr Do made highly selective disclosures both about her relationship with the patient and about the medications she was prescribing to him.¹⁰¹ Dr Wild treated and informally 'counselled' a patient who had very serious physical and mental illnesses (including, possibly, dissociative identity disorder) without any form of external referral to a mental health specialist

95 Note that Celenza and Gabbard state that 'many patients' who are sexually victimised by mental health care providers are 'actively suicidal at the time of the misconduct': Celenza and Gabbard (n 7) 625.

96 It is not clear in *Do* [2012] NSWMT 9 and *Wild* [2012] WASAT 37 whether the practitioner was the prescriber of the medication used in the overdose; in *Amigo* [2012] NSWMT 13 she was not.

97 *Do* [2012] NSWMT 9, [139], [140].

98 *Record of Investigation of Death: Helen Minett* [2014] Coroner's Court of Western Australia 12, 10 [40] (Coroner Linton).

99 *Amigo* [2012] NSWMT 13, [2].

100 *Do* [2014] NSWCA 307, [21] (Meagher JA).

101 *Ibid* [17] (Meagher JA).

or attempt at hospitalisation at times of acute crisis, based at least in part on the patient's stated aversion to the mental health system.¹⁰² It does not appear that any of these GPs had any form of specialist mental health training or accreditation.

Wild typifies a dual relationship setting in which professional judgement is clouded by personal considerations. Dr Wild did not call an ambulance when the patient fatally overdosed because, among other things, she knew the patient was deeply resistant to the idea of being submitted to the mental health system, and she had formed the view that the patient was incapable of overdosing on oral medication (due to gastric banding) based on reports from others about past overdose episodes involving smaller quantities of opiates. Furthermore, she did not even tell the patient's husband – who arrived later and was left with the sole care of the patient – about the overdose, because she knew that the patient wished to keep such matters from him. While there was no complaint in that case of a sexual relationship, the whole factual matrix is deeply inflected with concealment and secrecy: the practitioner kept a separate set of notes of her 'counselling' sessions with the patient which occurred outside of formal consultations, none of which appear to have been in evidence.

The *Wild* case also exemplifies the opacity of determinations when the practitioner and regulator have approached the Tribunal with an agreed set of facts and sanction. There is very scant information about the circumstances of the relationship or the practitioner's treatment,¹⁰³ leaving the public with little understanding of how the Tribunal came to conclude that the conduct 'had no element of abuse of trust or misuse of power'.¹⁰⁴ Notably, the Tribunal imposed conditions including a restriction on the practitioner, a GP, undertaking 'counselling' of any more than six sessions with any patient and preventing her from managing any patient 'by engaging in psychotherapy, including prayer therapy'.¹⁰⁵ The imposition of conditions on a practitioner's registration is only undertaken in order to protect the public. It is therefore a reasonable inference that some form of purported psychotherapy/'prayer therapy' was provided by this GP as her treatment of a very mentally unwell patient; yet there is absolutely no reference in the text of the decision as to whether this occurred, or what form this took.

Given the serious and sustained nature of the professional breaches – which occurred for between two and five years in these cases – and their gravity in the sense that they each involved a patient's death, it is notable that the outcomes imposed were at the lighter end of the scale, being: a reprimand and conditions (*Amigo*, 2012), a three-month suspension (*Wild*, 2012) and conditions (*Do*, 2013,

102 See *Record of Investigation of Death: Helen Minett* [2014] Coroner's Court of Western Australia 12.

103 Indeed it is not even apparent on the face of the Tribunal's decision that: the patient was a woman, the doctor and patient were pre-acquainted through a church group, the patient had very serious psychological issues including a belief that she was possessed and/or had multiple personalities, and the practitioner actually witnessed the patient's 'agonal' or dying breaths without identifying them as such. All of this information appears in the coronial report, which concluded that no further referral for proceedings against the doctor was required: *Record of Investigation of Death: Helen Minett* [2014] Coroner's Court of Western Australia 12.

104 *Wild* [2012] WASAT 37, [24].

105 *Ibid* ords 4(c)–(d).

overturned on appeal in 2014 and replaced by the NSW Court of Appeal with an order of deregistration accompanied by an 18-month non-review period). I do not mean to suggest that these practitioners were responsible for the loss of life, or that any suicide is ‘preventable’ in these or comparable circumstances. Rather, the improper relationship, and concomitant secrecy, dependence, and blurring of personal and professional responsibilities, was deeply implicated in the failure to provide appropriate care or to arrange alternative care – regardless of whether such care would have been successful. In this sense, although exceptional in terms of setting, these cases also typify relationship cases because the relationship impedes the provision of appropriate health care, regardless of the motivation of the practitioner.

VIII SAME-SEX RELATIONSHIPS

Celenza and Gabbard state that in their clinical experience of female analysts who have admitted sexual misconduct, the patient involved is ‘as likely’ to be female as male.¹⁰⁶ In two studies of female teachers who had been disciplined for sexual misconduct, and of female teachers and other professionals convicted of sexual abuse, respectively, the juvenile victims were female in a quarter of cases.¹⁰⁷ If the limited international literature is correct and the incidence of female same-sex sexual misconduct in professional settings is between 25 and 50%, then there appears to be significant under-reporting of such misconduct in the health disciplinary context.

In this case set there were two cases in which a female psychologist had an acknowledged sexual relationship with a female patient (and a further case, discussed above, in which there was an ‘enmeshed’ personal relationship between a female GP and female patient to whom she provided counselling).¹⁰⁸ There were no comparable cases in the misconduct dataset in which a male health practitioner had a sexual relationship with a male patient.¹⁰⁹

Many disciplinary cases of sexual misconduct do not arise from a complaint initiated by the patient herself or himself, but rather through a disclosure made by the patient to another health practitioner and that practitioner’s mandatory report, or a complaint by a patient’s spouse or family member. While it is common for patients to ‘protect’ practitioners with whom they are, or have been, in a relationship through non-complaint, prolonged periods of concealment and even, as noted above, through sworn denials and false evidence in favour of the practitioner, there are additional factors at play when the practitioner in question is the same sex as the patient. Despite shifting cultural norms and legal recognition

106 Celenza and Gabbard (n 7) 630.

107 Christensen and Darling (n 9) 29; Darling, Hackett and Jamie (n 11) 203.

108 There was also one case involving a psychologist in which the sex of both the practitioner and the patient was suppressed: see *The Registrant* [2013] QCAT 627.

109 But see *Nursing and Midwifery Board of Australia v Clydesdale* [2013] QCAT 191, in which the Tribunal accepted that while the relationship was not sexual or romantic, there were gifts, shared holidays and massages. There were also a handful of male patients in the contact cases.

of same-sex relationships in Australia in recent years, it remains the case that such a relationship may be more difficult to disclose than an opposite sex one, either because of concerns about homophobic reactions from others or internalised homophobia exacerbating self-blame or shame. Disclosure is likely to be particularly difficult if either or both the patient and practitioner either do not understand themselves to be lesbian, or do not openly identify as such socially or professionally, with the consequence that disclosure also constitutes an ‘outing’ for either or both parties.¹¹⁰

These cases merit close analysis to understand the gendered dynamics at play in the incidents themselves, and in the tribunal response to them. Again, I stress that this is not a question of whether such cases are ‘worse’ or ‘less worse’ than male–female sexual misconduct, or female–male sexual misconduct, but rather, the ways in which such offences are distinct. The two cases in the dataset demonstrate some interesting similarities. Both involved psychologists who were relatively inexperienced at the time, sexual relationships which took place in the midst of much longer friendships that both pre- and post-dated the sexual relationship, occurred in the early 2000s, and led to notifications after a long passage of time by the patient’s new treating psychologist, or at her urging.¹¹¹ In *Psychology Board of Australia v OYV* (‘*OYV*’) the treating relationship lasted two years, the subsequent personal relationship spanned 10 years, during two of which a committed sexual relationship took place, and the complaint was then made 11 years after the sexual relationship had ended (and four years after the friendship had ended). In *Psychology Board of Australia v van Megchelen* (‘*van Megchelen*’) there was originally a friendship, then two treatment sessions, a nine year subsequent friendship during which there was a single sexual encounter, and the complaint was then made six years after the sexual incident (and shortly after the dissolution of the friendship).

Both matters involved secrecy in the context of denial of, and hostility towards, lesbian identification. In *OYV* the patient and psychologist belonged to a church group, and it was the patient who ended the romantic relationship after two years when *OYV* refused to acknowledge it publicly.¹¹² In *van Megchelen* the patient and psychologist kept both the friendship and sexual relationship secret from the patient’s parents, who were deeply opposed to their daughter’s identification as gay and who appeared to blame the psychologist for ‘teaching’ her to be so. The acrimonious dissolution of the friendship was triggered by the psychologist objecting to being uninvited to a party (and also unfriended on Facebook) because

110 Similar barriers have been noted regarding reporting same-sex intimate partner violence, including fear of a homophobic response from authorities or being ‘outed’. See, eg, Lee Vickers, ‘The Second Closet: Domestic Violence in Lesbian and Gay Relationships’ (1996) 3(4) *eLaw Journal: Murdoch University Electronic Journal of Law* 11. See also Kate Seymour, ‘(In)Visibility and Recognition: Australian Policy Responses to “Domestic Violence”’ (2019) 22(5–6) *Sexualities* 751. While the Tribunal took the very unusual step of suppressing the name of the practitioner in *Psychology Board of Australia v OYV*, it is not clear whether the suppression was made on such a basis, as there is no reference to it in the reasons (which proceeded on the basis of agreed facts and sanction).

111 *Psychology Board of Australia v OYV (Review and Regulation)* [2016] VCAT 1687 (‘*OYV*’); *van Megchelen* [2013] VCAT 328.

112 *OYV* [2016] VCAT 1687, [26].

the patient wished to continue concealing their connection from her family after nine years.

Despite the pre-existing social relationship, very brief treating relationship and singular sexual incident in *van Megchelen*, the Tribunal ordered an 18-month suspension, and in lengthy reasoning characterised it as a more serious breach than the Tribunal did in the later case of *OYV* (which resulted in a six-month suspension). There are a number of factors that clearly support these differential assessments of seriousness: most notably that in *van Megchelen* there was an age difference of 15 years between psychologist and patient which was very significant in the context of the patient being only 16 years old when the social relationship began and the clinical consultations occurred, and her being just over 18 when the sexual conduct occurred. Moreover, in *OYV* the practitioner made more fulsome admissions and took more responsibility for what had occurred.

It is of some concern that the Tribunal may not have considered the ways in which prejudice informed the factual matrix or the practitioner's motivation and perspective on the events in *van Megchelen*. It was the practitioner's position that her relationship with the patient was originally a friendship in which she was supporting the 'coming out' of a young member of her community (a local surf club) who otherwise lacked such support, and that she offered family therapy sessions to that end.¹¹³ However, the Tribunal accepted at face value the evidence of the patient's mother that the parents were 'offended' and 'were made to feel alienated in their parental role and fearful of the undue emphasis' that the psychologist was giving to the issue of their (non)acceptance of their daughter's sexual orientation 'over other serious pre-existing psychological issues'.¹¹⁴ In doing so, the Tribunal accepted that material the practitioner provided to the parents was 'unduly weighted towards issues of gay sexuality' rather than her 'other psychological problems which had been clearly identified', and it found that her approach 'is likely to have exacerbated conflict within the family and ultimately delayed the provision of appropriate support services' to the patient.¹¹⁵ It does not seem beyond the realm of possibility that the patient's eating disorder, anxiety and depression were actually related to her process of coming to terms with her sexuality, and to her parents' hostility towards it, but these were at all times framed as mutually exclusive categories.

Following the two consultations, the father called the practitioner to tell her that her approach was 'too gay friendly'. The mother attributed the patient cutting her hair and 'dressing in a particular way' to the 'influence' and 'unhealthy effect' of the practitioner, and thereafter imposed a ban on any contact between them.¹¹⁶ The Tribunal accepted that this was 'in an effort to protect her daughter'.¹¹⁷ Yet the parents also prohibited their daughter from telling her siblings or grandparents about her sexuality.¹¹⁸ Even with such apparent indications of entrenched familial

113 See, eg, *van Megchelen* [2013] VCAT 328, [138]–[139].

114 *Ibid* [103], [107].

115 *Ibid* [108].

116 *Ibid* at [109], [110] and [141] respectively.

117 *Ibid* [116], [142].

118 *Ibid* [194].

homophobia (characterised as ‘perceived parental antagonism’ and ‘apprehension’), the Tribunal still found that the continuation of the friendship through several years of adulthood, against the wishes of the parents, was as an aggravating factor.¹¹⁹

Recollecting that many female practitioners benefited from the implication of ‘genuineness’ that came through their open conduct of a one-off primary romantic relationship with a patient or former patient, the fact that such openness was not present in the two same-sex cases is notable. In same-sex cases, concealment and secrecy should not be taken necessarily as evidence of exploitation or other self-serving motive, as it may well be a response to inequality rather than an attempt to avoid taking responsibility. While not in any way minimising the seriousness of the misconduct in *van Megchelen*, involving as it did sustained blurring of boundaries and a significant power differential (neither of which the practitioner fully acknowledged), it is possible that the specific dynamics of a same-sex relationship against a background context of intense homophobia may not have been fully appreciated in that case.

While the two cases analysed above may not form a basis from which any general conclusions can be drawn, they do highlight a number of important issues for consideration. These include the possibility that female practitioners may not appreciate that there is a power imbalance in a relationship with a female patient, because there is no gendered power imbalance, or because they see themselves as members of the same minority community, and/or that they see sexual orientation as cutting across the profession barrier. There may also be a higher likelihood of concealment or secrecy behaviours in the conduct of the relationship and, relatedly, a greater possibility of underreporting arising from the experience of homophobia (including notifier concern about ‘outing’ of the practitioner and/or patient, or the patient’s feelings of solidarity, or continuing friendship at the end of the relationship).

IX CONCLUSION

Examining the publicly available disciplinary decisions provides an understanding of how, in these most serious of matters, decision-makers assess severity and determine outcomes. These cases demonstrate that sexual misconduct by female health practitioners is taken seriously by the Australian health regulatory system. The overall ‘lighter’ sanctions for female practitioners compared to male practitioners in sexual misconduct disciplinary proceedings is justified by a number of factors. First, it must be recollected that women and men cannot be compared across the entire category of ‘sexual misconduct’ because women’s offending takes place entirely within the context of improper relationships and does not encompass ‘contact’ offences.

119 See *ibid* [106], [186]; see also *van Megchelen* [2013] VCAT 395, [23], in which the Tribunal apparently accepted the applicant’s submissions on this point.

While a significant number of the relationship cases involving male practitioners noted that the patient had presented with a history of sexual abuse or violence, none of the cases involving female practitioners did so. Women also appeared quite likely to be in a medium term primary romantic relationship with the patient, and to conduct such a relationship openly (and even to present at the hearing with the relationship still intact, and with the support of the patient). These factors weigh towards assessments of lesser severity because of less acute patient vulnerability and a lower likelihood that the tribunal would judge the practitioner as behaving in an exploitative manner. Involvement with a single patient in all but one of the female cases is arguably of most significance, because it allowed for the finding that the practitioner had committed a once-off error of judgement rather than ethical corruption or endemic boundary failures.

Nonetheless, 27 of the 28 cases resulted in a finding of professional misconduct. This means that practitioners were not 'let off the hook' in terms of the finding of the level of breach of professional duties and the message sent to the profession about where sexual misconduct falls on the scale of impropriety. Rather, the above factors were influential in the assessment of risk to the public in terms of the future practice of the professional and the likelihood of recurrence.

There were some striking cross-currents that flowed against an overall trend of lesser severity in the female cases. In particular there appeared to be a widespread failure among the female practitioners in relationships with male patients to appreciate the significance of structural vulnerability in the therapeutic relationship – or even, in some cases, the specific vulnerability of the male patient. There was also a notable over-representation of incarcerated patients in the cohort. There appeared to be an alarming propensity to blur caregiving and romanticised rescue fantasies in the context of incarcerated and suicidal patients, with whom sexual and intimate relationships were characterised as a form of 'helping'.

It is notable that there were no female dental practitioners or pharmacists at all. Of the other three major professions, female doctors and nurses appeared at much lower rates than their professional ratios, while female psychologists were over-represented. Mental health practitioners dominated the female relationship cases, and even among general medical and nursing practice, mental health settings and presenting issues were the norm. It is worth considering whether this context, or confluence of factors, represents one of particular susceptibility for female practitioners, and what common factors appear across the three professions represented in the case set. All of the cases involved therapeutic relationships with high levels of interpersonal contact and potential for emotional intimacy, with limited oversight of the treatment or treating relationship by other professionals.

Many of the cases examined arguably fit within the 'lovesick' typology posited by Gabbard in which the professional, in the midst of personal crisis, slides down a slippery slope beginning with personal disclosure and then experiences the attraction to the patient as a 'true love affair' and pursues it within a fantasy of mutual rescue.¹²⁰ This typology was more, not less, apparent when the patient was in truly acute settings, in particular, patient incarceration or prolonged suicidality.

120 See also Faulkner and Regehr (n 10).

In these latter cases, practitioners engaged in a form of unbounded self-sacrifice in what they understood to be attempts to rescue/heal the patient within a merged personal and professional relationship of blurred caregiving. This research suggests that a self-conception of altruism and feminised tropes of (romanticised) caregiving¹²¹ may pose challenges to professional boundaries that have been largely unrecognised. The feminisation, and relative power differentials, of the various health professions may need to be considered in more detail as part of any regulatory response.

This research contends that simply comparing outcomes or indicia of severity as between male and female practitioner matters risks treating male cases as a benchmark and missing the distinctiveness of female misconduct. Female sexual misconduct in any professional setting – and in the health setting in particular – has been little analysed and is arguably not well understood. While this is a small case set, it provides important insight into the dynamics at play in the most serious cases involving female Australian health practitioners in the major health professions.

Even bearing in mind the modest pool of cases from which these findings are drawn, this analysis should give pause to health regulators in considering how to formulate, apply and monitor professional rules on sexual boundaries. I suggest there is a need for rethinking in order to target ethical guidance and training on sexual misconduct in a gender-specific way. Simply put, men and women may be doing the ‘same’ thing in different ways, for different reasons, which gender-neutral approaches fail to recognise and address. This research suggests that female health professionals – in particular psychologists and other mental health care professionals – could benefit from ethical training that addressed the specific dynamics of transference in mental health settings when the practitioner is female and the patient male, and also of the unique dynamics when the patient and practitioner are both female and same-sex attracted. In all cases a greater focus on, and more nuanced understanding of, the romanticisation of caregiving for female health practitioners appears to be called for.

121 See Mary Chiarella and Amanda Adrian, ‘Boundary Violations, Gender and the Nature of Nursing Work’ (2014) 21(3) *Nursing Ethics* 267.